CHAPTER VII

REHABILITATION HOSPITAL REIMBURSEMENT AND APPEALS OF REIMBURSEMENT RATES

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HOSPITAL REIMBURSEMENT

The Department of Medical Assistance Services (DMAS) reimburses participating facilities on a cost-related basis for care provided to eligible program recipients (see Chapter IV for a description of those items and services that are considered allowable costs). DMAS utilizes the Medicare Principles of Cost Reimbursement (PRM-15) as modified by the Program in determining allowable costs.

This chapter includes information from Virginia's Medicaid State Plan for Medical Assistance regarding the manner in which hospital providers are reimbursed. It also includes details regarding how a hospital may appeal the reimbursement rates determined by DMAS. See the "Methods and Standards" and "Appeals" sections below.

GENERAL

For inpatient hospital services, the system provides for prospective rate determination of allowable costs. Annually, prospective operating cost rates are determined by increasing the actual allowable costs at the rate of increase in the appropriate inflation factor, subject to the peer group ceiling. The system provides incentives to efficiently operated facilities. Relief from the operating cost ceiling is available to hospitals that qualify for the disproportionate share adjustment and/or as otherwise provided through the appeals system. Capital costs and direct education costs are pass-throughs and are reimbursed retrospectively at actual costs as determined through the annual cost report.

Outpatient services are reimbursed retrospectively on a cost-related basis.

For payment rates to non-enrolled or out-of-state hospitals, refer to the non-enrolled provider section under "Methods and Standards" in this chapter.

Cost Reporting

Rehabilitation hospitals and rehabilitation units of acute care hospitals are required to maintain separate cost accounting records and to file a cost report annually using the applicable Medicare cost reporting forms (HCFA-2552 series) and the Medicaid forms (DMAS-783 series).

Notice of Program Reimbursement (NPR)

As soon as the cost report is settled by DMAS, an NPR and all supporting data will be sent by certified letter to the provider. In those instances where additional monies are due the provider, the fiscal agent will be notified of the amount due, and a check will be prepared. The settlement check will be mailed to the provider approximately 10 working days after the date of the NPR. In those instances where the provider owes monies to DMAS, the provider will be given 30 days from the date of the NPR to liquidate the overpayment without any interest penalties. See the "Refund of Overpayments" section regarding overpayments and interest charges.

Providers may appeal the final determination of program reimbursement within 30 days of the date of the NPR. Refer to appeals section in this chapter for specific guidance.

Inquiries

Inquiries concerning the payment system, allowable cost, accounting procedure, submission of cost reports, and other cost-related matters should be directed to:

Division of Cost Settlement and Audit
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219
Telephone: (804) 786-7931

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT CARE

DMAS will pay the reasonable cost of inpatient hospital services provided under the State Plan. In reimbursing hospitals for the cost of inpatient hospital services provided to recipients of Medical Assistance, the following methods and standards apply:

I. For each hospital also participating in the Health Insurance for the Aged program under Title XVIII of the Social Security Act, the State agency applies the same standards, cost reporting period, cost reimbursement principles, and method of cost apportionment currently used in computing reimbursement to such a hospital under Title XVIII of the Act, except that the inpatient routine services costs for Medical Assistance recipients will be determined subsequent to the application of the Title XVIII method of apportionment, and the calculation will exclude the applicable Title XVIII inpatient routine service charges or patient days as well as Title XVIII inpatient routine service costs.

II. For each hospital not participating in the Program under Title XVIII of the Act, the State agency applies the standards and principles described in 42 CFR 447.250 and either (a) one of the available alternative cost apportionment methods in 42 CFR 447.250, or (b) the "Gross RCCAC method" of cost apportionment applied as follows: For a reporting period,

the total allowable hospital inpatient charges; the resulting percentage is applied to the bill of each inpatient under the Medical Assistance Program.

III. For either participating or non-participating facilities, DMAS reimburses no more in the aggregate for inpatient hospital services than the amount it is estimated would be paid for the services under the Medicare principles of reimbursement, as set forth in 42 CFR 447.253(b)(2) and/or the lessor of reasonable cost or customary charges in 42 CFR 447.250.

IV. DMAS applies the standards and principles described in the State Plan on a demonstration or experimental basis for the payment of reasonable costs by methods other than those described in the preceding sections I, II, and III.

V. The reimbursement system for hospitals includes the following components:

(1) Hospitals are grouped by classes according to number of licensed beds and urban versus rural. (Three groupings for rural -- 0 to 100 beds, 101 to 170 beds, and over 170 beds; four groupings for urban -- 0 to 100, 101 to 400, 401 to 600; and over 600 beds.) These groupings are similar to those used by the Health Care Financing Administration (HCFA) in determining routine cost limitations.

(2) Prospective reimbursement ceilings on allowable operating costs were established as of July 1, 1982, for each grouping. Hospitals with a fiscal year-end after June 30, 1982, are subject to the new reimbursement ceilings.

The calculation of the initial group ceilings as of July 1, 1982, was based on available, allowable cost data for all hospitals in calendar year 1981. Individual hospital operating costs were advanced by a reimbursement escalator from the hospital's year end to July 1, 1982. After this advancement, the operating costs were standardized using SMSA wage indices, and a median was determined for each group. These medians were readjusted by the wage index to set an actual cost ceiling for each SMSA. Therefore, each hospital grouping has a series of ceilings representing one of each SMSA area. The wage index was based on those used by HCFA in computing its Market Basket Index for routine cost limitations.

Effective July 1, 1986, and until June 30, 1988, providers under the prospective payment system of reimbursement had their prospective operating cost rate and prospective operating cost ceiling computed using a different methodology. This method used an allowance for inflation based on the percent of change in the quarterly average of the Medical Care Index of the Wharton Econometrics - Standard Forecast determined in the quarter in which the provider's new fiscal year began.

The prospective operating cost rate is based on the provider's allowable cost from the most recently filed cost report, plus the inflation percentage add-on.

The prospective operating cost ceiling is determined by using the base that was in effect for the provider's fiscal year that began between July 1, 1985, and June 1, 1986. The medical care index percent of change for the quarter in which the provider's new fiscal year began is added to this base to determine the new operating cost ceiling. This new ceiling was effective for all providers on July 1, 1986. For subsequent cost reporting periods beginning on or after July 1, 1986, the last prospective operating rate ceiling determined under this methodology is the base for computing the next prospective year ceiling.

Effective on or after July 1, 1988, and until June 30, 1989, for providers subject to the prospective payment system, the allowance for inflation is based on the percent of change in the moving average of the Data Resources Incorporated Health Care Cost HCFA-Type Hospital Market Basket determined in the quarter in which the provider's new fiscal year begins. Such providers will have their prospective operating cost rate and prospective operating cost ceilings established in accordance with the methodology which became effective July 1, 1986. Rates and ceilings in effect July 1, 1988, for all such hospitals were adjusted to reflect this change.

Effective on and after July 1, 1989, for providers subject to the prospective payment system, the allowance for inflation will be based on the percent of change in the moving average of the Health Care Cost HCFA-Type Hospital Market Basket, adjusted for Virginia, as developed by Data Resources, Incorporated, determined in the quarter in which the provider's new fiscal year begins. Such providers will have their prospective operating cost rate and prospective operating cost ceiling established in accordance with the methodology which became effective July 1, 1986. Rates and ceilings in effect July 1, 1989, for all such hospitals will be adjusted to reflect this change.

Effective on and after July 1, 1992, for providers subject to the prospective payment system, the allowance for inflation, as described above, which became effective on July 1, 1989, shall be converted to an escalation factor by adding two percentage points, (200 basis points) to the then current allowance for inflation. The escalation factor shall be applied in accordance with the inpatient hospital reimbursement methodology in effect on June 30, 1992. On July 1, 1992, the conversion to the new escalation factor shall be accomplished by a transition methodology which, for non-June 30 year

end hospitals, applies the escalation factor to escalate their payment rates for the months between July 1, 1992 and their next fiscal year ending on or before May 31, 1993.

This method still requires comparison of the prospective operating cost rate to the prospective operating ceiling. The provider is allowed the lower of the two amounts subject to the lower of cost or charges principles.

(3) Subsequent to June 30, 1992, the group ceilings are not recalculated on allowable costs, but are updated by the escalator.

(4) Prospective rates for each hospital are based upon the hospital's allowable costs plus the escalator factor, or the appropriate ceilings, or charges; whichever is lower. Except to eliminate costs that are found to be unallowable, no retrospective adjustments are made to prospective rates.

Depreciation, capital interest, and direct education costs approved pursuant to PRM-15 (Sec. 400), are considered pass-throughs and not part of the calculation.

(5) An incentive plan is established whereby a hospital will be paid on a sliding scale, percentage for percentage, up to 25 percent of the difference between allowable operating costs and the appropriate per diem group ceiling when the operating costs are below the ceilings. The incentive is calculated based on the annual cost report.

The table below presents four examples under the new plan:

Group Ceiling	Allowable Cost Per Day	$	Difference % of Ceiling	$	Sliding Scale Incentive % of Difference
$230	$230	0	0%	0	0%
230	207	23.00	10%	2.30	10%
230	172	58.00	25%	14.50	25%
230	154	76.00	33%	19.00	25%

(6) Special consideration for an exception to the median operating cost limits is available in those instances where extensive neonatal care is provided. **(This section is not applicable to rehabilitation providers.)**

(7) Hospitals which have a disproportionately higher level of Medicaid

patients and which exceed the ceiling shall be allowed a higher ceiling based on the individual hospital's Medicaid utilization. This shall be measured by the percent of Medicaid patient days to total hospital patient days. Each hospital with a Medicaid utilization of over 8.0% shall receive an adjustment to its ceiling. The adjustment shall be set at a percent added to the ceiling for each percent of utilization of up to 30%.

Disproportionate Share Hospitals (DSH) Defined

Effective July 1, 1988, the following criteria shall be met before a hospital is determined to be eligible for a disproportionate share payment adjustment.

A. Criteria

l. A Medicaid inpatient utilization rate in excess of 8% for hospitals receiving Medicaid payments in the Commonwealth, or a low-income patient utilization rate exceeding 25% (as defined in the Omnibus Budget Reconciliation Act of 1987 and as amended by the Medicare Catastrophic Coverage Act of 1988); and

2. At least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under a State Medicaid plan. In the case of a hospital located in a rural area (that is, an area outside of a Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures.

3. Subsection A.2 does not apply to a hospital:

a. At which the inpatients are predominantly individuals under 18 years of age; or

b. Which does not offer nonemergency obstetric services as of December 21, 1987.

B. Payment Adjustment

1. Hospitals which have a disproportionately higher level of Medicaid patients shall be allowed a disproportionate share payment adjustment based on the type of hospital and on the individual hospital's Medicaid utilization. There shall be

two types of hospitals: (i) Type One, consisting of state-owned teaching hospitals, and (ii) Type Two, consisting of all other hospitals. The Medicaid utilization shall be determined by dividing the number of Medicaid inpatient days by the total number of inpatient days. Each hospital with a Medicaid utilization of over 8% shall receive a disproportionate share payment adjustment.

2. For Type One hospitals, the disproportionate share payment adjustment shall be equal to the product of (i) the hospital's Medicaid utilization in excess of 8%, times eleven, times (ii) the lower of the prospective operating cost rate or ceiling. For Type Two hospitals, the disproportionate share payment adjustment shall be equal to the product of (i) the hospital's Medicaid utilization in excess of 8%, times (ii) the lower of the prospective operating cost rate or ceiling.

(8) Outlier Adjustment

a. DMAS shall pay all enrolled hospitals an outlier adjustment in payment amounts for medically necessary inpatient hospital services provided on or after July 1, 1991, involving exceptionally high costs for individuals under one year of age.

b. DMAS shall pay to disproportionate share hospitals (as defined in V.(7) above) an outlier adjustment in payment amounts for medically necessary inpatient hospital services provided on or after July 1, 1991, involving exceptionally high costs for individuals under six years of age.

c. The Outlier Adjustment Calculation

(1) Each eligible hospital which desires to be considered for the adjustment shall submit a log which contains the information necessary to compute the mean of its Medicaid per diem operating cost of treating individuals identified in (8) a or b above. This log shall contain all Medicaid claims for such individuals, including, but not limited to: (i) the patient's name and Medicaid identification number; (ii) the dates of service; (iii) the remittance date paid; (iv) the number of covered days; and (v) the total charges for the length of stay. Each hospital shall then calculate the per diem operating cost (which excludes capital and education) of treating such patients by multiplying the charge for each patient by the Medicaid operating cost-to-charge ratio determined from its annual cost report.

(2) Each eligible hospital shall calculate the mean of its Medicaid per diem operating cost of treating individuals identified in (8) a or b above. Any hospital which qualifies for the extensive neonatal care provision (as governed by V.(6) above) shall calculate a separate mean for the cost of providing extensive neonatal care to individuals identified in (8) a or b above.

(3) Each eligible hospital shall calculate its threshold for payment of the adjustment, at a level equal to two-and-one-half standard deviations above the mean or means calculated in (8)c(2) above.

d. DMAS shall pay as an outlier adjustment to each eligible hospital all per diem operating costs which exceed the applicable threshold or thresholds for that hospital.

Each eligible hospital will be responsible for providing to DMAS, information from which its mean Medicaid operating cost per day can be computed. To claim the additional payment, each eligible hospital must submit with its annual cost report a log which computes the adjustment (see Exhibit VII.1 for the calculation of the adjustment). See Exhibit VII.2 for the manual calculation of the standard deviation.

VI. In accordance with Title 42 Sections 447.250 through 447.272 of the Code of Federal Regulations which implements Section 1902(a)(13)(A) of the Social Security Act, the Department of Medical Assistance Services ("DMAS") establishes payment rates for services that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated facilities to provide services in conformity with State and federal laws, regulations, and quality and safety standards. To establish these rates, Virginia uses the Medicare principles of cost reimbursement in determining the allowable costs for Virginia's prospective payment system. Allowable costs will be determined from the filing of a uniform cost report by participating providers. The cost reports are due not later than 90 days after the provider's fiscal year end. If a complete cost report is not received within 90 days after the end of the provider's fiscal year, the Program shall take action in accordance with its policies that an overpayment is not being made.

EXHIBIT VII.1

OUTLIER ADJUSTMENT CALCULATION

OUTLIER ADJUSTMENT CALCULATION

Model: LOGG
27-JUN-1990
09:09:36 AM

Hospital ABC Hospital_____ FYE_____6/30/90 Provider No. __49-0000-0__

Log of Medicaid Claims for Children less than 1 year of Age from July 1, 1989 through June 30, 1990

	1 Name	2 Medicaid I.D. No.	3 Dates Of Service	4 Remittance Date Paid	5 Total Covered Days	6 Total Charges	7 Oper. Cost To Charges Ratio (1)	8 Operating Cost (C6*C7)	9 Operating Cost Per Diem (C8/C5)	10 Threshold Per Diem	11 Outlier Per Diem Adj (C9-C10)	12 Outlier Payment (C11*C5)
1	Jones	11111111	10/1/89 - 10/2/89	01/05/90	1	500.00	68.00%	340.00	340.00	1,205.20	0.00	0.00
2	Smith	2222222	07/1/89 - 07/2/89	09/01/89	1	400.00	68.00%	272.00	272.00	1,205.20	0.00	0.00
3	Brown	3333333	07/1/89 - 07/4/89	09/10/89	3	800.00	68.00%	544.00	181.33	1,205.20	0.00	0.00
4	Abrams	444444	08/1/89 - 08/8/89	10/02/89	7	2,000.00	68.00%	1,360.00	194.29	1,205.20	0.00	0.00
5	Cook	5555555	09/1/89 - 09/6/89	11/15/89	5	10,000.00	68.00%	6,800.00	1,360.00	1,205.20	154.80	774.00
6	Griffin	66666666	12/1/89 - 12/2/89	01/15/90	1	450.00	68.00%	306.00	306.00	1,205.20	0.00	0.00
7	Reed	7777777	01/1/90 - 01/3/90	02/15/90	2	600.00	68.00%	408.00	204.00	1,205.20	0.00	0.00
8	Green	888888	02/1/90 - 02/4/90	03/20/90	3	850.00	68.00%	578.00	192.67	1,205.20	0.00	0.00
9	Taylor	999999	10/1/89 - 10/2/89	12/15/89	1	480.00	68.00%	326.40	326.40	1,205.20	0.00	0.00
10	White	123456	11/1/89 - 11/2/89	01/05/90	1	300.00	68.00%	204.00	204.00	1,205.20	0.00	0.00
	Total								3,580.69			
	Mean (Average)								358.07			
	Standard Deviation (STD) From Mean (See Example 2) = 338.85											
	Plus 2 1/2 Standard Deviations (338.85 * 2 1/2) =								847.13			
	Threshold (Mean + 2 1/2 STD)- Transfer to Col 10 above								1,205.20			
	Total Outlier Payment (transfer to Exb. E, Part III, Col 1, Line 2)											774.00

(1) Ratio = from Medicaid Cost Report
Inpatient Medicaid Operating Costs (Exb. E-1, Part A, line 3) 868,360
_____ = _____ = 68.00%
Inpatient Medicaid Charges (Exb. D, Line 4) 1,277,000

EXHIBIT VII.2

CALCULATION OF STANDARD DEVIATION (STD)

The "standard deviation" is a measure of the extent of variation from the mean (average) in a group of items, in this case, the operating cost per diems. There are two formulas for calculating standard deviation, population STD and sample STD.

The DMAS will use the population STD formula. If a hospital wishes to utilize one of the many commercially available software packages to facilitate the calculation of the STD, please ensure that the package uses the population formula to calculate the STD (e.g., LOTUS 1-2-3).

For those hospitals which treat relatively few children and do not wish to utilize a software package for calculation of the STD, the population STD formula and an example of the STD calculation are provided below:

Formula: $\sigma = \sqrt{\frac{\Sigma (x-u)^2}{N}}$

σ = Population Standard Deviation

u = Population Mean (Average)

x = Item (Per Diem)

N = Size of Population (Number of Per Diems)

Σ = "Sum of"

EXHIBIT VII.2 (continued)

EXAMPLE CALCULATION FROM EXHIBIT VII.1

	x	u	x-u	$(x-u)^2$
1	$340.00	$358.07	(18.07)	$326.52
2	272.00	358.07	(86.07)	7,408.04
3	181.33	358.07	(186.74)	31,237.03
4	194.29	358.07	(163.78)	26,823.89
5	1,360.00	358.07	1,001.93	l,003,863.72
6	306.00	358.07	(52.07)	2,711.28
7	204.00	358.07	(154.07)	23,737.56
8	192.67	358.07	(165.40)	27,357.16
9	326.40	358.07	(31.67)	1,002.99
10	204.00	358.07	(154.07)	23,737.56
Total	$3,580.69 / 10 =	$358.07	0	

$$\Sigma (x-u)^2 = \$1,148,205.75$$

$$\sqrt{\frac{\Sigma (x-u)^2}{N}} = \sqrt{\frac{1,148,205.75}{10}} = \sqrt{114,820.58}$$

$$\sigma = \sqrt{114,820.58} = \$338.85$$

Population STD - $338.85 (See page 9.)

The cost report will be judged complete when DMAS has all of the following:

- Completed cost reporting form(s) provided by DMAS, with signed certification(s);
- The provider's trial balance showing adjusting journal entries;
- The provider's financial statements including, but not limited to, a balance sheet, a statement of income and expense, a statement of retained earnings (or fund balance), a statement of changes in financial position, and footnotes to the financial statements;
- Schedules which reconcile financial statements and trial balance to expenses claimed in the cost report;
- Home office cost report, if applicable; and
- Such other analytical information or supporting documents requested by DMAS when sending the cost reporting forms to the provider.

Although utilizing the cost apportionment and cost finding methods of the Medicare Program, Virginia does not adopt the prospective payment system of the Medicare Program enacted October 1, 1983.

VII. Revaluation of Assets

A. Effective October 1, 1984, the valuation of an asset of a hospital or long-term care facility which has undergone a change of ownership on or after July 18, 1984, is the lesser of the allowable acquisition cost to the owner of record as of July 18, 1984 or the acquisition cost to the new owner.

B. In the case of an asset not in existence as of July 18, 1984, the valuation of an asset of a hospital or long-term care facility is the lesser of the first owner of record or the acquisition cost to the new owner.

C. In establishing an appropriate allowance for depreciation, interest on capital indebtedness, and return on equity (if applicable), the base to be used for such computations is limited to A or B above.

D. Costs (including legal fees, accounting, and administrative costs, travel costs, and feasibility studies) attributable to the negotiation or settlement of the sale or purchase of any capital asset (by acquisition or merger) are reimbursable only to the extent that they have not been previously reimbursed by Medicaid.

E. The recapture of depreciation up to the full value of the asset is required.

F. Rental charges in sale and leaseback agreements are restricted to the depreciation, mortgage interest, and (if applicable) return on equity based on the cost of ownership as determined in accordance with A. and B. above.

VIII. Refund of Overpayments - Effective August 5, 1988

A. **Lump Sum Payment.** When the provider files a cost report indicating that an overpayment has occurred, full refund shall be remitted with the cost report. In cases where DMAS discovers an overpayment during a desk review, field audit, or final settlement, DMAS will promptly send the first demand letter requesting a lump sum refund. Recovery shall be undertaken even though the provider disputes in whole or in part DMAS' determination of the overpayment.

B. **Offset.** If the provider has been overpaid for a particular fiscal year and has been underpaid for another fiscal year, the underpayment shall be offset against the overpayment. As long as the provider has an overpayment balance, any underpayments discovered by subsequent review or audit shall also be used to reduce the remaining amount of the overpayment.

C. **Payment Schedule.** If the provider cannot refund the total amount of the overpayment at the time it files a cost report indicating that an overpayment has occurred, the provider shall request an extended repayment schedule at the time of filing or within 30 days after receiving the DMAS demand letter.

DMAS may establish a repayment schedule of up to 12 months to

recover all or part of an overpayment or, if a provider demonstrates that repayment within a 12-month period would create severe financial hardship, the Director of the Department of Medical Assistance Services (the director) may approve a repayment schedule of up to 36 months.

A provider shall have no more than one extended repayment schedule in place at one time. If an audit later uncovers an additional overpayment, the full amount shall be repaid within 30 days unless the provider submits further documentation supporting a modification to the existing extended repayment schedule to include the additional amount.

If, during the time an extended repayment schedule is in effect, the provider withdraws from the Program or fails to file a cost report in a timely manner, the outstanding balance shall become immediately due and payable.

When a repayment schedule is used to recover only part of an overpayment, the remaining amount shall be recovered by the reduction of interim payments to the provider or by lump sum payments.

D. **Extension Request Documentation.** In the request for an extended repayment schedule, the provider shall document the need for an extended (beyond 30 days) repayment and submit a written proposal scheduling the dates and amounts of repayments. If DMAS approves the schedule, DMAS shall send the provider written notification of the approved repayment schedule, which shall be effective retroactive to the date the provider submitted the proposal.

E. **Interest Charge on Extended Repayment.** Once an initial determination of overpayment has been made, DMAS shall undertake full recovery of such overpayment even if the provider disputes, in whole or in part, the initial determination of overpayment. If an appeal follows, interest shall be waived during the period of administrative appeal of an initial determination of overpayment.

Interest charges on the unpaid balance of any overpayment shall accrue pursuant to §32.1-313 of the Code of Virginia from the date the director's determination becomes final. (Effective July 1, 1991, the applicable rate of interest is 9 percent per year, as enacted by the 1991 General Assembly.)

The director's determination shall be deemed to be final on (i) the due date of any cost report filed by the provider indicating that an overpayment has occurred, or (ii) the issue date of any notice of overpayment, issued by DMAS, if the provider does not file an appeal, or (iii) the issue date of any administrative decision issued by DMAS after an informal fact finding conference, if the provider does not file an appeal, or (iv) the issue date of any administrative decision signed by the director, regardless of whether a judicial appeal follows. In any event, interest shall be waived if the overpayment is completely liquidated within 30 days of the date of the final determination. In cases in which a determination of overpayment has been judicially reversed, the provider shall be reimbursed that portion of the payment to which it is entitled, plus any applicable interest which the provider paid to DMAS.

As prescribed in Section 32.1-313, Code of Virginia, interest accrued on overpayments and interest on funds borrowed specifically to repay overpayments shall not be reimbursed as an allowable cost.

IX. Effective October 1, 1986, hospitals that have obtained Medicare certification as inpatient rehabilitation hospitals or rehabilitation units in acute care hospitals, which are excluded from the Medicare Prospective Payment System (DRG), shall be reimbursed in accordance with the current Medicaid Prospective Payment System as described in the preceding sections I, II, III, IV, V, VI, VII, and VIII but excluding V.(6). Additionally, rehabilitation hospitals and rehabilitation units of acute care hospitals which are excluded from the Medicare Prospective Payment System will be required to maintain separate cost accounting records, and to file separate cost reports annually utilizing the applicable Medicare cost report forms (HCFA-2552 series) and the Medicaid forms (DMAS-783 series).

A new facility will have an interim rate determined using a pro forma cost report or detailed budget prepared by the provider and accepted by DMAS, which represents its anticipated allowable cost for the first cost reporting period of participation. For the first cost reporting period, the provider will be held to the lesser of its actual operating costs or its peer group ceiling. Subsequent rates will be determined in accordance with the current Medicaid Prospective Payment System as noted in the preceding paragraph.

X. Item 398D of the 1987 Appropriation Act (as amended), effective April 18, 1987, eliminated reimbursement of return on equity capital to proprietary providers.

XI. Pursuant to Item 389 E4 of the 1988 Appropriation Act (as amended), effective July 1, 1988, a separate group ceiling for allowable operating costs shall be established for state-owned university teaching hospitals.

XII. Non-Enrolled Providers

A. Non-enrolled hospitals submitting claims to DMAS shall be paid based on the DMAS average reimbursable inpatient cost-to-charge ratio, updated annually, for enrolled hospitals less five percent. The five percent is for the cost of the additional manual processing of the claims. Non-enrolled hospitals shall submit claims using the required DMAS invoice formats. Such claims must be submitted within 12 months from the date of service. A hospital is determined to regularly treat Virginia Medicaid recipients and shall be required by DMAS to enroll if it provides more than 500 days of care to Virginia Medicaid recipients during the hospital's financial fiscal year. A hospital required by DMAS to enroll shall be reimbursed in accordance with the current Medicaid Prospective System as described in the preceding Sections I, II, III, IV, V, VI, VII, VIII, IX, and X. The hospital shall be placed in the DMAS peer grouping which most nearly reflects its licensed bed size and location (Section V.(1) above). These hospitals shall be required to maintain separate cost accounting records and to file separate cost reports annually, utilizing the applicable Medicare cost reporting forms (HCFA 2552 Series) and the Medicaid forms (MAP-783 Series).

B. A newly-enrolled facility shall have an interim rate determined using the provider's most recent filed Medicare cost report or a pro forma cost report or detailed budget prepared by the provider and accepted by DMAS, which represents its anticipated allowable cost for the first cost reporting period of participation. For the first cost reporting period, the provider shall be limited to the lesser of its actual operating costs or its peer group ceiling. Subsequent rates shall be determined in accordance with the current Medicaid Prospective Payment System as noted in the preceding paragraph of XII.A.

C. Once a hospital has obtained the enrolled status, 500 days of care, the hospital must agree to become enrolled as required by DMAS to receive reimbursement. This status shall continue during the entire term of the provider's current Medicare certification and subsequent recertification or until mutually terminated with 30 days written notice by either party. The provider must maintain this enrolled status

to receive reimbursement. If an enrolled provider elects to terminate the enrollment agreement, the non-enrolled reimbursement status will not be available to the hospital for future reimbursement, except for emergency care.

D. Prior approval must be received from the DMAS Quality Care Assurance Division when a referral has been made for treatment to be received from a non-enrolled acute care facility (in-state or out-of-state), except in the case of an emergency or because medical resources or supplementary resources are more readily available in another state.

E. Non-enrolled outpatient hospitals submitting claims to DMAS shall be paid on the DMAS average reimbursable outpatient cost-to-charge ratio, updated annually, for enrolled outpatient hospitals less five percent. The five percent is for the cost of the additional manual processing of the claims. Non-enrolled outpatient hospitals shall submit claims on DMAS invoices.

F. Nothing in this regulation is intended to preclude DMAS from reimbursing for special services, such as rehabilitation, ventilator, and transplantation, on an exception basis and reimbursing for these services on an individually-negotiated rate basis.

HOSPITAL APPEALS OF REIMBURSEMENT RATES
(FINAL REGULATIONS FOR HOSPITAL APPEALS OF REIMBURSEMENT RATES)

Section 1. Right to Appeal an Initial Agency Decision

A. **Right to Appeal:** Any hospital seeking to appeal its prospective payment rate for operating costs related to inpatient care or other allowable costs must submit a written request to the Department of Medical Assistance Services within 30 days of the date of the letter notifying the hospital of its prospective rate unless permitted to do otherwise under Section 5E. The written request for appeal must contain the information specified in Section 1B. The Department shall respond to the hospital's request for additional reimbursement within 30 days or after receipt of any additional documentation requested by the Department, whichever is later. Such agency response shall be considered the initial agency determination.

B. **Required Information:** Any request to appeal the prospective payment rate must specify: (i) the nature of the adjustment sought; (ii) the amount of the adjustment sought; and (iii) current and prospective cost containment efforts, if appropriate.

C. **Non-Appealable Issues:** The following issues will not be subject to appeal: (i) the organization of participating hospitals into peer groups according to location and bed size and the use of bed size and the urban/rural distinction as a generally adequate proxy for case mix and wage variations between hospitals in determining reimbursement of inpatient care; (ii) the use of Medicaid and applicable Medicare Principles of Reimbursement to determine reimbursement of costs other than operating costs relating to the provision of inpatient care; (iii) the calculation of the initial group ceilings on allowable operating costs for inpatient care as of July 1, 1982; (iv) the use of an appropriate inflation factor determined by DMAS as the prospective escalator; and (v) durational limitations set forth in the State Plan (the "twenty-one day rule").

D. The rate which may be appealed shall include costs which are for a single cost reporting period only.

E. The hospital shall bear the burden of proof throughout the administrative process.

Section 2. Administrative Appeal of Adverse Initial Agency Determination

A. **General:** The administrative appeal of **an** adverse initial agency determination shall be made in accordance with the Virginia Administrative Process Act, Sections 9-6.14:11 through 9-6.14:14 of the Code of Virginia, as set forth below.

B. **The Informal Proceeding:**

1. The hospital must submit a written request to appeal an adverse initial agency determination in accordance with Section 9-6.14:11 of the Code of Virginia within 15 days of the date of the letter transmitting the initial agency determination.

2. The request for an informal conference in accordance with Section 9-6.14:11 of the Code of Virginia shall include the following information:

   a. The adverse agency action appealed from;

   b. A detailed description of the factual data, argument or information the hospital will rely on to challenge the adverse agency decision.

3. The agency shall afford the hospital an opportunity for an informal conference in accordance with Section 9-6.14:11 of the Code of Virginia within 45 days of the request.

4. The Director of the Division of Cost Settlement and Audit of the Department of Medical Assistance Services, or his designee, shall preside over the informal conference. As hearing officer, the Director, or his designee, may request such additional documentation or information from the hospital or agency staff as may be necessary in order to render an opinion.

5. After the informal conference, the Director of the Division of Cost Settlement and Audit, having considered the criteria for relief set forth in Sections 4 and 5, shall take any of the following actions:

   a. Notify the provider that its request for relief is denied setting forth the reasons for such denial; or

   b. Notify the provider that its appeal has merit and advise it of the agency action which will be taken; or

   c. Notify the provider that its request for relief will be granted in part and denied in part, setting forth the reasons for the denial in part and the agency action which will be taken to grant relief in part.

6. The decision of the informal hearing officer shall be rendered within 30 days of the conclusion of the informal conference.

Section 3. The Formal Administrative Hearing: Procedures

A. The hospital must submit its written request for a formal administrative hearing under Section 9-6.14:12 of the Code of Virginia within 15 days of the date of the letter transmitting the adverse informal agency decision.

B. At least 21 days prior to the date scheduled for the formal hearing, the hospital shall provide the agency with:

   1. Identification of the adverse agency action appealed from, and

   2. A summary of the factual data, argument, and proof the provider will rely on in connection with its case.

C. The agency shall afford the provider an opportunity for a formal administrative hearing within 45 days of the receipt of the request.

D. The Director of the Department of Medical Assistance Services, or his designee, shall preside over the hearing. Where a designee presides, he shall make recommended findings and a recommended decision to the

Director. In such instance, the provider shall have an opportunity to file exceptions to the proposed findings and conclusions. In no case shall the designee presiding over the formal administrative hearing be the same individual who presided over the informal appeal.

E. The Director of the Department of Medical Assistance Services shall make the final administrative decision in each case.

F. The decision of the agency shall be rendered within 60 days of the conclusion of the administrative hearing.

Section 4. The Formal Administrative Hearing: Necessary Demonstration of Proof

A. The hospital shall bear the burden of proof in seeking relief from its prospective payment rate.

B. A hospital seeking additional reimbursement for operating costs relating to the provision of inpatient care shall demonstrate that its operating costs exceed the limitation on operating costs established for its peer group and set forth the reasons for such excess.

C. In determining whether to award additional reimbursement to a hospital for operating costs relating to the provision of inpatient care, the Director of the Department of Medical Assistance Services shall consider the following:

1. Whether the hospital has demonstrated that its operating costs are generated by factors generally not shared by other hospitals in its peer group. Such factors may include, but are not limited to, the addition of new and necessary services, changes in case mix, extraordinary circumstances beyond the control of the hospital, and improvements imposed by licensing or accrediting standards.

2. Whether the hospital has taken every reasonable action to contain costs on a hospital-wide basis.

a. In making such a determination, the Director or his designee may require that an appellant hospital provide quantitative data, which may be compared to similar data from other hospitals within that hospital's peer group or from other hospitals deemed by the Director to be comparable. In making such comparisons, the Director may develop operating or financial ratios which are indicators of performance quality in particular areas of hospital

operation. A finding that the data or ratios or both of the appellant hospital fall within a range exhibited by the majority of comparable hospitals may be construed by the Director to be evidence that the hospital has taken every reasonable action to contain costs in that particular area. Where applicable, the Director may require the hospital to submit to the agency the data it has developed for the Virginia Health Services Cost Review Commission. The Director may use other data, standards, or operating screens acceptable to him. The appellant hospital shall be afforded an opportunity to rebut ratios, standards, or comparisons utilized by the Director or his designee in accordance with this section.

b. Factors to be considered in determining cost containment may include the following:

- Average daily occupancy
- Average hourly wage
- FTEs per adjusted occupied bed
- Nursing salaries per adjusted patient day
- Average length of stay
- Average cost per surgical case
- Cost (salary/non-salary) per ancillary procedure
- Average cost (food/non-food) per meal served
- Average cost per pound of laundry
- Cost (salary/non-salary) per pharmacy prescription
- Housekeeping cost per square foot
- Maintenance cost per square foot
- Medical records cost per admission
- Current Ratio (current assets to current liabilities)
- Age of receivables
- Bad debt percentage
  Inventory turnover
- Measures of case mix

c. In addition, the Director may consider the presence or absence of the following systems and procedures in determining effective cost containment in the hospital's operation:

- Flexible budgeting system
- Case mix management systems
- Cost accounting systems
- Materials management system
- Participation in group purchasing arrangements

- Productivity management systems
- Cash management programs and procedures
- Strategic planning and marketing
- Medical records systems
- Utilization/peer review systems

d. Nothing in this provision shall be construed to require a hospital to demonstrate every factor set forth above or to preclude a hospital from demonstrating effective cost containment by using other factors.

The Director or his designee may require that an on-site operational review of the hospital be conducted by the Department or its designee.

3. Whether the hospital has demonstrated that the Medicaid prospective payment rate it receives to cover operating costs related to inpatient care is insufficient to provide care and service that conforms to applicable State and federal laws, regulations, and quality and safety standards.[1]

D. In no event shall the Director of the Department of Medical Assistance Services award additional reimbursement to a hospital for operating costs relating to the provision of inpatient care, unless the hospital demonstrates to the satisfaction of the Director that the Medicaid rate it receives under the Medicaid prospective payment system is insufficient to ensure Medicaid recipients reasonable access to sufficient inpatient hospital services of adequate quality.[2] In making such demonstration, the hospital shall show that:

1. The current Medicaid prospective payment rate jeopardizes the long-term financial viability of the hospital. Financial jeopardy is presumed to exist if, by providing care to Medicaid recipients at the current Medicaid rate, the hospital can demonstrate that it is, in the aggregate, incurring a marginal loss.[3]

For purposes of this section, marginal loss is the amount by which total variable costs for each patient day exceed the Medicaid payment rate. In calculating marginal loss, the hospital shall compute variable costs at 60 percent of total inpatient operating costs and fixed costs at 40 percent of total inpatient operating costs; however, the Director may accept a different ratio of fixed and variable operating costs if a hospital is able to demonstrate that a different ratio is appropriate for its particular institution.

Financial jeopardy may also exist if the hospital is incurring a marginal gain but can demonstrate that it has unique and compelling Medicaid costs, which if unreimbursed by Medicaid, would clearly jeopardize the hospital's long-term financial viability and,

2. The population served by the hospital seeking additional financial relief has no reasonable access to other inpatient hospitals. Reasonable access exists if most individuals served by the hospital seeking financial relief can receive inpatient hospital care within a 30 minute travel time at a total per diem rate which is less to Department of Medical Assistance Services than the costs which would be incurred by DMAS per patient day where the appellant hospital granted relief.[4]

E. In determining whether to award additional reimbursement to a hospital for reimbursable costs which are other than operating costs related to the provision of inpatient care, the Director shall consider Medicaid and applicable Medicare rules of reimbursement.

Section 5. Available Relief

A. Any relief granted under Sections 1-4 shall be for one cost reporting period only.

B. Relief for hospitals seeking additional reimbursement for operating costs incurred in the provision of inpatient care shall not exceed the difference between:

1. The cost per allowable Medicaid day arising specifically as a result of circumstances identified in accordance with Section 4 (excluding plant and education costs and return on equity capital) **and**

2. The prospective operating cost per diem identified in the Medicaid Cost Report and calculated by DMAS.[5]

C. Relief for hospitals seeking additional reimbursement for (i) costs considered as "pass-throughs" under the prospective payment system or (ii) costs incurred in providing care to a disproportionate number of Medicaid recipients or (iii) costs incurred in providing extensive neonatal care shall not exceed the difference between the payment made and the actual allowable cost incurred.

D. Any relief awarded under Sections 1-4 shall be effective from the first day of the cost period for which the challenged rate was set. Cost periods for which relief will be afforded are those which begin on or after January 4, 1985. In no case shall this limitation apply to a hospital which noted an appeal of its prospective payment rate for a cost period prior to January 4, 1985.

E. All hospitals for which a cost period began on or after January 4, 1985, but prior to March 3, 1986, shall be afforded an opportunity to be heard in accordance with these regulations if the request for appeal set forth in Section 1A was filed within 90 days of March 3, 1986.

Section 6. Catastrophic Occurrence

A. Nothing in Sections 1-5 shall be construed to prevent a hospital from seeking additional reimbursement for allowable costs incurred as a consequence of a natural or other catastrophe. Such reimbursement will be paid for the cost period in which such costs were incurred and for cost periods beginning on or after July 1, 1982.

B. In order to receive relief under this section, a hospital shall demonstrate that the catastrophe met the following criteria:

1. One time occurrence;

2. Less than 12 months duration;

3. Could not have been reasonably predicted;

4. Not of an insurable nature;

5. Not covered by federal or State disaster relief;

6. Not a result of malpractice or negligence.

C. Any relief sought under this section must be calculable and auditable.

D. The agency shall pay any relief afforded under this section in a lump sum.

FOOTNOTES

1. See 42 U.S.C. Section 1396a(a)(13)(A). This provision reflects the Commonwealth's concern that she reimburse only those excess operating costs which are incurred because they are needed to provide adequate care. The Commonwealth recognizes that hospitals may choose to provide more than "just adequate" care and, as a consequence, incur higher costs. In this regard, the Commonwealth notes that "Medicaid programs do not guarantee that each recipient will receive that level of health care precisely tailored to his or her particular needs. Instead, the benefit provided through Medicaid is a particular package of health care services . . . that package of services has the general aim of assuring that individuals will receive necessary medical care, but the benefit provided remains the individual services offered -- not 'adequate health care'." Alexander v. Choate, - U.S. - decided January 9, 1985, 53 U. S. L.W., 4072, 4075.

2. In Mary Washington Hospital v. Fisher, the court ruled that the Medicaid rate" must be adequate to ensure reasonable access. "Mary Washington Hospital v. Fisher, at p. 18. The need to demonstrate that the Medicaid rate is inadequate to ensure recipients reasonable access derives directly from federal law and regulations. In its response to comments on the NPRM published September 30, 1981, HCFA points out Congressional intent regarding the access issue:

   The report on H.R. 3982 states the expectation that payment levels for inpatient services will be adequate to assure that a sufficient number of facilities providing a sufficient level of services actively participate in the Medicaid program to enable all Medicaid beneficiaries to obtain quality inpatient services. This report further states that payments should be set at a level that ensures the active treatment of Medicaid patients in a majority of the hospitals in the state. (46. Federal Register 47970)

3. The Commonwealth believes that Congressional intent is threatened in situations in which a hospital is incrementally harmed for each additional day a Medicaid patient is treated -- and therefore has good cause to consider withdrawal from the program -- and where no alternative is readily available to the patient, should withdrawal occur. Otherwise, although the rate being paid a hospital may be less than that paid by other payors -- indeed, less than average cost per day for all patients -- it nonetheless equals or exceeds the variable cost per day, and therefore benefits the hospital by offsetting some amount of fixed costs, which it would incur even if the bed occupied by the Medicaid patient were left empty.

   It should be emphasized that application of this marginal loss or "incremental harm" concept is a device to assess the potential harm to a hospital continuing to treat Medicaid recipients, and not a mechanism for determining the additional payment due to a successful appellant. As discussed below, once a threat to access has been demonstrated, the Commonwealth may participate in the full average costs associated with the circumstances underlying the appeal.

4. With regard to the 30-minute travel standard, this requirement is consistent with general health planning criteria regarding acceptable travel time for hospital care.

5. The Commonwealth recognizes that in cases where circumstances warrant relief beyond the existing payment rate, she may share in the cost associated with those circumstances. This is consistent with the existing policy, whereby payment is made on an average per diem basis. The Commonwealth will not reimburse more than her share of fixed costs. Any relief to an appellant hospital will be computed using patient days adjusted for the level of occupancy during the period under appeal. In no case will any additional payments made under this rule reflect lengths of stay which exceed the twenty-one day limit currently in effect.

DISPUTE RESOLUTION FOR STATE-OPERATED PROVIDERS

§1. Definitions.

DMAS means the Department of Medical Assistance Services.

Division Director means the Director of a division of DMAS.

State-operated provider means a provider of Medicaid services which is enrolled in the Medicaid program and operated by the Commonwealth of Virginia.

§2. Right to request reconsideration.

A. A state-operated provider shall have the right to request a reconsideration for any issue which would be otherwise administratively appealable under the State Plan by a non-state operated provider. This shall be the sole procedure available to state-operated providers.

B. The appropriate DMAS Division must receive the reconsideration request within 30 calendar days after the provider receives its Notice of Amount of Program Reimbursement, notice of proposed action, findings letter, or other DMAS notice giving rise to a dispute.

§3. Informal review. The state-operated provider shall submit to the appropriate DMAS Division written information specifying the nature of the dispute and the relief sought. If a reimbursement adjustment is sought, the written information must include the nature of the adjustment sought; the amount of the adjustment sought; and the reasons for seeking the adjustment. The Division Director or his designee shall review this information, requesting additional information as necessary. If either party so requests, they may meet to discuss a resolution. Any designee shall then recommend to the Division Director whether relief is appropriate in accordance with applicable law and regulations.

§4. Division Director action. The Division Director shall consider any recommendation of his designee and shall render a decision.

§5. DMAS Director review. A state-operated provider may, within 30 days after receiving the informal review decision of the Division Director, request that the DMAS Director or his designee review the decision of the Division Director. The DMAS Director shall have the authority to take whatever measures he deems appropriate to resolve the dispute.

§6. Secretarial review. If the preceding steps do not resolve the dispute to the satisfaction of the state-operated provider, within 30 days after receipt of the decision of the DMAS Director, the provider may request the DMAS Director to refer the matter to the Secretary of Health and Human Resources and any other Cabinet Secretary as appropriate. Any determination by such Secretary or Secretaries shall be final.

METHOD FOR RATE CALCULATION - HOSPITAL PAYMENT SYSTEM

General

Effective July 1, 1986, the following changes have been made to the Prospective Payment Plan:

- The current inflation factor, which is the Bureau of Labor Statistics Consumer Price Index (CPI) less the housing and interest components, will be changed to the Medical Care Index of the Wharton Econometrics - Standard Forecast (MCPI).

- Instead of using the previous 12-month average of the inflation factor, a forecasted value will be used.

- Instead of using a two-step approach of first inflating the previous year's base and then calculating a new ceiling, the previous year's ceiling will be inflated by a factor based upon the forecasted value of the MCPI.

- The provider's actual allowable average operating per diem costs for the previous year will be inflated by a factor based upon the forecasted value of the MCPI.

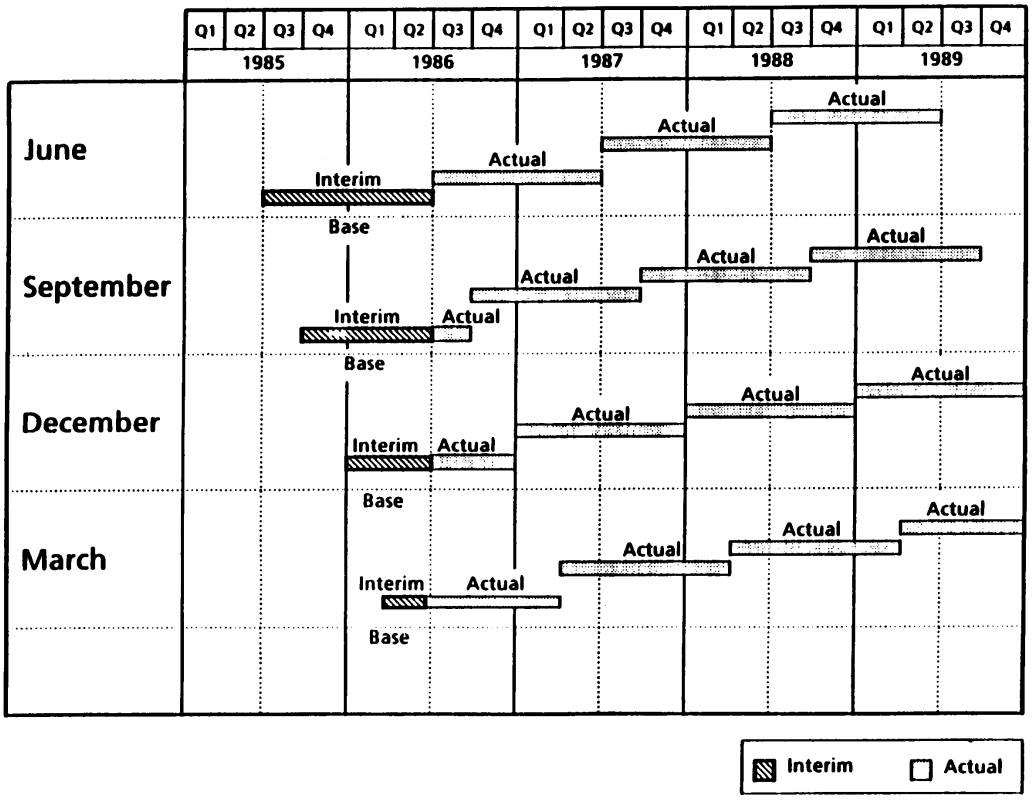
Ceiling Methodology

The following methodology will be used to establish ceilings for providers under the changed reimbursement plan:

- To establish the actual ceiling effective for all providers on July 1, 1986, the base in effect for the State's fiscal year ending June 30, 1986 will be used as the starting point to calculate an interim ceiling. This interim ceiling will be carried forward from the provider's fiscal year which ends during the State's fiscal year July 1, 1985 to June 30, 1986 to the provider's fiscal year which ends on or after June 30, 1986.

EXHIBIT VII.3

EXHIBIT VII.3



- If the provider's fiscal year ends on June 30, 1986, a new ceiling is calculated and becomes the actual ceiling for the period from July 1, 1986 to June 30, 1987.

- If the provider's fiscal year ends after June 30, 1986, the ceiling in effect on June 30, 1986 becomes the actual ceiling on July 1, 1986 for the remainder of the provider's fiscal year.

- This methodology is illustrated for various providers in Exhibit VII.3.

Rate Calculations

To establish a prospective per diem operating rate to be effective on July 1, 1986, the following methodology will be used:

- The provider's actual allowable average per diem operating rate for the provider's fiscal year ending between July 1, 1985 and June 30, 1986 will be the starting point.

- The actual allowable average per diem operating cost will be increased by a historical medical component of the Consumer Price Index (MCPI) factor to establish an interim per diem operating rate which will then be increased by a forecast MCPI factor to establish a preliminary per diem operating rate. The preliminary per diem operating rate will be compared to the provider's actual ceiling (see ceiling calculations). The actual per diem operating rate will be the lower of the actual ceiling or the preliminary per diem operating rate.

- The actual per diem operating rate established in the second step above will be added to the provider's allowable pass-through cost per diems and will be carried forward to the provider's fiscal year which ends between July 1, 1986 and June 30, 1987.

- Effective July 1, 1986, the prospective per diem rates established in the second and third steps above will be implemented for reimbursement of all providers until the next fiscal year.

- At the end of the next fiscal year, the actual allowable average per diem operating cost will be increased by an historical MCPI factor to establish an interim per diem operating rate which will be increased by a forecast MCPI factor to establish a preliminary per diem operating rate. The preliminary per diem operating rate will be compared to the actual ceiling for the next fiscal year, and the lower of the two will become the actual per diem operating rate for the next fiscal year.

- This process will be carried out for the remainder of the biennium.

Formulas for Calculation of Ceilings and Costs

June Provider

1. **Ceiling**

   a. Fiscal year July 1985 to June 30, 1986:

      1) Use June 1986 document.

      2) Increase July 1, 1985 to June 30, 1986 base by historical MCPI 2/85 to 2/86 to obtain an interim ceiling.

   b. Fiscal year July 1, 1986 to June 30, 1987:

      1) Use June 1986 document.

      2) Increase 85-86 ceiling by 1/2 forecasted MCPI 2/86 to 2/87 to get 86-87 ceiling.

   c. Fiscal year July 1, 1987 to June 30, 1988:

      1) Use July 1987 document.

      2) Recalculate 86-87 ceiling by increasing 85-86 ceiling by historical MCPI 2/86 to 2/87.

      3) Increase recalculated 86-87 ceiling by 1/2 forecasted MCPI 2/87 to 2/88.

2. **Costs**

   a. Fiscal year July 1, 1986 to June 30, 1987:

      1) Use the June 1986 document.

      2) Increase the July 1, 1985 to June 30, 1986 actual allowable average per diem operating cost by 1/2 historical MCPI 2/85 to 2/86 to establish an interim per diem operating rate.

      3) Increase the interim per diem operating rate by 1/2 forecasted MCPI 2/86 to 2/87 to establish a preliminary per diem operating rate which will be compared to the ceiling. The lower of the two becomes the actual per diem operating rate.

   b. Fiscal year July 1, 1987 to June 30, 1988:

      1) Use the July 1987 document.

2) Increase the actual allowable average per diem operating cost for fiscal year 1986 to 1987 by 1/2 historical MCPI 2/86 to 2/87 to establish an interim per diem operating rate.

3) Increase the interim per diem operating rate by 1/2 forecasted MCPI 2/87 to 2/88 to establish a preliminary per diem operating rate which will be compared to the ceiling. The lower of the two becomes the actual per diem operating rate.

September Provider

1. **Ceiling**

a. Fiscal year October 1985 to September 1986:

1) Use June 1986 document.

2) Increase July 1, 1985 to June 30, 1986 base by historical MCPI 3/85 to 2/86 and 1/2 forecasted MCPI 2/86 to 3/86 to obtain an interim ceiling.

b. Fiscal year October 1986 to September 1987:

1) Use October 1986 document.

2) Recalculate the 85-86 ceiling by increasing the July 1, 1985 to June 30, 1986 base by historical MCPI 3/85 to 3/86.

3) Increase recalculated ceiling by 1/2 forecasted MCPI 3/86 to 3/87.

c. Fiscal year October 1987 to September 1988:

1) Use October 1987 document.

2) Recalculate October 1986 to September 1987 ceiling by increasing October 1985 to September 1986 ceiling by historical MCPI 3/86 to 3/87.

3) Increase recalculated October 1986 to September 1987 ceiling by 1/2 forecasted MCPI 3/87 to 3/88.

2. **Costs**

a. Fiscal year October 1985 to September 1986:

1) Use the June 1986 document.

2) Increase the October 1984 to September 1985 actual allowable average per diem operating costs by 1/2 historical MCPI 3/84 to 3/85 and by 1/2 forecasted MCPI 3/85 to 3/86 to establish a preliminary per diem operating rate which will be compared to the ceiling. The lower of the two becomes the actual per diem operating rate.

b. Fiscal year October 1986 to September 1987:

1) Use the October 1986 document.

2) Increase the October 1985 to September 1986 actual allowable average per diem operating cost by 1/2 historical MCPI 3/85 to 3/86 to establish an interim per diem operating rate.

3) Increase the interim per diem operating rate by 1/2 forecasted MCPI 3/86 to 3/87 to establish a preliminary per diem operating rate which will be compared to the ceiling. The lower of the two becomes the actual per diem operating rate.

c. Fiscal year October 1987 to September 1988:

1) Use October 1987 document.

2) Increase October 1986 to September 1987 actual allowable average per diem operating cost by 1/2 historical MCPI 3/86 to 3/87 to establish an interim per diem operating rate.

3) Increase the interim per diem operating rate by 1/2 forecasted MCPI 3/87 to 3/88 to establish a preliminary per diem operating rate which will be compared to the ceiling. The lower of the two becomes the actual per diem operating rate.

December Provider

1. **Ceiling**

a. Fiscal year January 1986 to December 1986:

1) Use the June 1986 document.

2) Increase the July 1, 1985 to June 30, 1986 base by historical MCPI 4/85 to 2/86 and 1/2 forecasted MCPI 2/86 to 4/86 to obtain an interim ceiling.

b. Fiscal year January 1987 to December 1987:

1) Use January 1987 document.

2) Recalculate the January 1, 1986 to December 31, 1986 ceiling by increasing the July 1, 1985 to June 30, 1986 base by historical MCPI 4/85 to 4/86.

3) Increase recalculated 85-86 ceiling by 1/2 forecasted MCPI 4/86 to 4/87 to obtain new ceiling.

c. Fiscal year January 1987 to December 1988:

1) Use January 1988 document.

2) Recalculate 86-87 ceiling by increasing 85-86 ceiling by historical MCPI 4/86 to 4/87.

3) Increase recalculated 86-87 ceiling by 1/2 forecasted value of MCPI 4/87 to 4/88.

2. **Costs**

a. Fiscal year January 1986 to December 1986:

1) Use June 1986 document.

2) Increase the January 1985 to December 1985 actual allowable average per diem operating costs by 1/2 historical MCPI 4/84 to 4/85 and by 1/2 forecasted MCPI 4/85 to 4/86 to establish a preliminary per diem operating rate which will be compared to the ceiling. The lower of the two becomes the actual per diem operating rate.

b. Fiscal year January 1987 to December 1987:

1) Use January 1987 document.

2) Increase the actual allowable average per diem operating cost for January 1, 1986 to December 31, 1986 by 1/2 historical MCPI 4/85 to 4/86 to establish an interim per diem operating rate.

3) Increase the interim per diem operating rate by 1/2 forecasted MCPI 4/86 to 4/87 to establish a preliminary per diem operating rate which will be compared to the ceiling. The lower of the two becomes the actual per diem operating rate.

c. Fiscal year January 1988 to December 1988:

1) Use January 1988 document.

2) Increase the actual allowable average per diem operating cost from January 1987 to December 1987 by 1/2 historical MCPI 4/86 to 4/87 to establish an interim per diem operating rate.

3) Increase the interim per diem operating rate by 1/2 forecasted MCPI 4/87 to 4/88 to establish a preliminary per diem operating rate which will be compared to the ceiling. The lower of the two becomes the actual per diem operating rate.

March Provider

1. **Ceilings**

a. Fiscal year April 1986 to March 1987:

1) Use June 1986 document.

2) Increase the July 1, 1985 to June 30, 1986 base by the historical MCPI 1/86 to 2/86 and 1/2 forecasted MCPI 2/86 to 1/87 to obtain an interim ceiling.

b. Fiscal year April 1987 to March 1988:

1) Use April 1987 document.

2) Recalculate the 86-87 ceiling by increasing the July 1, 1985 to June 30, 1986 base by the historical MCPI 1/86 to 1/87.

3) Increase the recalculated ceiling by 1/2 forecasted MCPI 1/87 to 1/88.

c. Fiscal year April 1988 to March 1989:

1) Use April 1988 document.

2) Recalculate the April 1987 to March 1988 ceiling by increasing the April 1986 to March 1987 ceiling by the historical MCPI 1/87 to 1/88.

3) Increase the recalculated April 1987 to March 1988 ceiling by 1/2 forecasted MCPI 1/88 to 1/89.

2. **Costs**

a. Fiscal year April 1986 to March 1987:

1) Use June 1986 document.

2) Increase the April 1985 to March 1986 actual allowable average per diem operating cost by 1/2 historical MCPI 1/85 to 1/86 to establish an interim per diem operating rate.

3) Increase the interim rate by 1/2 forecasted MCPI 1/86 to 1/87 to establish preliminary per diem operating rate which will be compared to the ceiling. The lower of the two becomes the actual per diem operating rate.

b. Fiscal year April 1987 to March 1988:

1) Use April 1987 document.

2) Increase actual average allowable per diem operating costs from April 1986 to March 1987 by 1/2 historical MCPI 1/86 to 1/87 to establish an interim per diem operating rate.

3) Increase the interim per diem operating rate by 1/2 forecasted MCPI 1/87 to 1/88 to establish preliminary per diem operating rate which will be compared to the ceiling. The lower of the two becomes the actual per diem operating rate.

c. Fiscal year April 1988 to March 1989:

1) Use April 1988 document.

2) Increase actual average allowable per diem operating costs from April 1987 to March 1988 by 1/2 historical MCPI 1/87 to 1/88 to establish an interim per diem operating rate.

3) Increase the interim per diem operating rate by 1/2 forecasted MCPI 1/88 to 1/89 to establish preliminary per diem operating rate which will be compared to the ceiling. The lower of the two becomes the actual per diem operating rate.

The following sections contain sample rate calculations using the above-described methodology.

Example 1: June Provider - Hospital (Norfolk Area 101 - 400 Beds)

CEILING CALCULATION (June Wharton)

Base 7/1/85-6/30/86	X	History (2/85-2/86)	=	Interim Ceiling
$262.70	X	1.0745	=	$282.27
Interim Ceiling	X	.5 Forecast (2/86-2/87)	=	Ceiling 7/1/86-6/30/87
$282.27	X	1.0302	=	$290.79

COST CALCULATION (June Wharton)

AAAPD 7/1/85-6/30/86	X	.5 History (2/85-2/86)	=	Interim Rate
$434.78	X	1.0373	=	$451.00
Interim Rate	X	.5 Forecast (2/86-2/87)	=	Preliminary Rate
$451.00	X	1.0302	=	$464.62

Preliminary Rate vs. Ceiling
$464.62 $290.79

Actual Per Diem Operating Rate	$290.79
Plant Cost	58.33
Education Cost	.57
Profit	0.00
Total Prospective Per Diem 7/1/86-6/30/87	$349.69
Current Rate 7/1/86-6/30/87	$326.61

Example 2: September Provider - Hospital (Richmond Area 0 - 100 Beds)

Transition 7/1/86-9/30/86

CEILING CALCULATION (June Wharton)

Base 7/1/85-6/30/86	X	(History + .5 Forecast) (3/85-2/86 2/86-3/86)	=	Ceiling
$272.04	X	1.0670		$290.27

COST CALCULATION (June Wharton)

AAAPD 10/1/84-9/30/85	X	.5 History (3/84-3/85)	=	Interim Rate
$305.79	X	1.0321	=	$315.61
Interim Rate	X	.5 Forecast (3/85-3/86)	=	Preliminary Rate
$315.61	X	1.0385	=	$327.76

Preliminary Rate vs. Ceiling
$327.76 $290.27

Actual Per Diem Operating Rate	$290.27
Plant Cost	16.49
Education Cost	0.00
Profit	0.00
Total Prospective Per Diem	$306.76
Settled Rate 9/30/86	$295.33

Example 2: September Provider (continued) - Hospital

Full Fiscal Year 10/1/86-9/30/87

CEILING CALCULATION (October Wharton)

Base 7/1/85-6/30/86	X	History (3/85-3/86)	=	Recalculated Ceiling
$272.04	X	1.0760	=	$292.72
Recalculated Ceiling	X	.5 Forecast (3/86-3/87)	=	Ceiling
$292.72	X	1.0332	=	$302.44

COST CALCULATION (October Wharton)

AAAPD 10/1/85-9/30/86	X	.5 History (3/85-3/86)	=	Interim Rate
$346.71	X	1.0380	=	$359.88
Interim Rate	X	.5 Forecast (3/86-3/87)	=	Preliminary Rate
$359.88	X	1.0332	=	$371.83

Preliminary Rate vs. Ceiling
$371.83 $302.44

Actual Per Diem Operating Rate	$302.44
Plant Cost	20.80
Education Cost	0.00
Profit	0.00
Total Prospective Per Diem 10/1/86-9/30/87	$323.24
Current Rate 10/1/86-9/30/87	$298.03

Example 3: December Provider - Hospital (N. VA 101 - 400 Beds)

Transition 7/1/86-12/31/86

CEILING CALCULATION (June Wharton)

Base 7/1/85-6/30/86	X	(History + .5 Forecast) (4/85-2/86 2/86-4/86)	=	Ceiling
$304.52	X	1.0556	=	$321.45

COST CALCULATION (June Wharton)

AAAPD 1/1/85-12/31/85	X	.5 History (4/84-4/85)	=	Interim Rate
$487.66	X	1.0330	=	$503.75
Interim Rate	X	.5 Forecast (4/85-4/86)	=	Preliminary Rate
$503.75	X	1.0355	=	$521.63

Preliminary Rate vs. Ceiling
$521.63 $321.45

Actual Per Diem Operating Rate	$321.45
Plant Cost	16.60
Education Cost	0.00
Profit	0.00
Total Prospective Per Diem	$338.05
Settled Rate 12/31/86	$330.56

Example 3: December Provider (continued) - Hospital

Full Fiscal Year 1/1/87-12/31/87

CEILING CALCULATION (January Wharton)

Base 7/1/85-6/30/86	X	History (4/85-4/86)	=	Recalculated Ceiling
$304.52	X	1.0767	=	$327.88
Recalculated Ceiling	X	.5 Forecast (4/86-4/87)	=	Ceiling
$327.88	X	1.0319	=	$338.34

COST CALCULATION (January Wharton)

AAAPD 1/1/86-12/31/86	X	.5 History (4/85-4/86)	=	Interim Rate
$568.50	X	1.0384	=	$590.33
Interim Rate	X	.5 Forecast (4/86-4/87)	=	Preliminary Rate
$590.33	X	1.0319	=	$609.16

Preliminary Rate vs. Ceiling
$609.16 $338.34

Actual Per Diem Operating Rate	$338.34
Plant Cost	36.54
Education Cost	0.00
Profit	0.00
Total Prospective Per Diem 1/1/87-12/31/87	$374.88
Current Rate 1/1/87-12/31/87	$345.02

Example 4: March Provider - Hospital (Rural 170+ Beds))

Transition 7/1/86-3/31/87

CEILING CALCULATION (June Wharton)

Base 7/1/85-6/30/86	X	(History + .5 Forecast) (1/86-2/86 2/86-1/87)	=	Ceiling
$203.83	X	1.0439	=	$212.78

COST CALCULATION (June Wharton)

AAAPD 4/1/85-3/31/86	X	.5 History (1/85-1/86)	=	Interim Rate
$316.74	X	1.0357	=	$328.05
Interim Rate	X	.5 Forecast (1/86-1/87)	=	Preliminary Rate
$328.05	X	1.0337	=	$339.11

Preliminary Rate vs. Ceiling
$339.11 $212.78

Actual Per Diem Operating Rate	$212.78
Plant Cost	33.99
Education Cost	0.00
Profit	0.00
Total Prospective Per Diem 7/1/86-3/31/87	$246.77
Current Rate 7/1/86-3/31/87	$240.27

Example 4: March Provider (continued) - Hospital

Full Fiscal Year 4/1/87-3/31/87

CEILING CALCULATION (April Wharton)

Base 7/1/85-6/30/86	X	History (1/86-1/87)	=	Recalculated Ceiling
$203.86	X	1.0720	=	$218.54
Recalculated Ceiling	X	.5 Forecast (1/87-1/88)	=	Ceiling
$218.54	X	1.0270	=	$224.44

COST CALCULATION (April Wharton)

AAAPD 4/1/86-3/31/87	X	.5 History (1/86-1/87)	=	Interim Rate
$356.40	X	1.0360	=	$369.23
Interim Rate	X	.5 Forecast (1/87-1/88)	=	Preliminary Rate
$369.23	X	1.0270	=	$379.20

Preliminary Rate vs. Ceiling
$379.20 $224.44

Actual Per Diem Operating Rate	$224.44
Plant Cost	38.80
Education Cost	0.00
Profit	0.00
Total Prospective Per Diem 4/1/87-3/31/88	$263.24
Current Rate 4/1/87-3/31/88	$240.27